What do Safeguarding Adult Reviews (SARs) tell us about deaths among people who are homeless? Focus on Self-Neglect

Primary Care Safeguarding Forum: Annual Conference 12 March 2021

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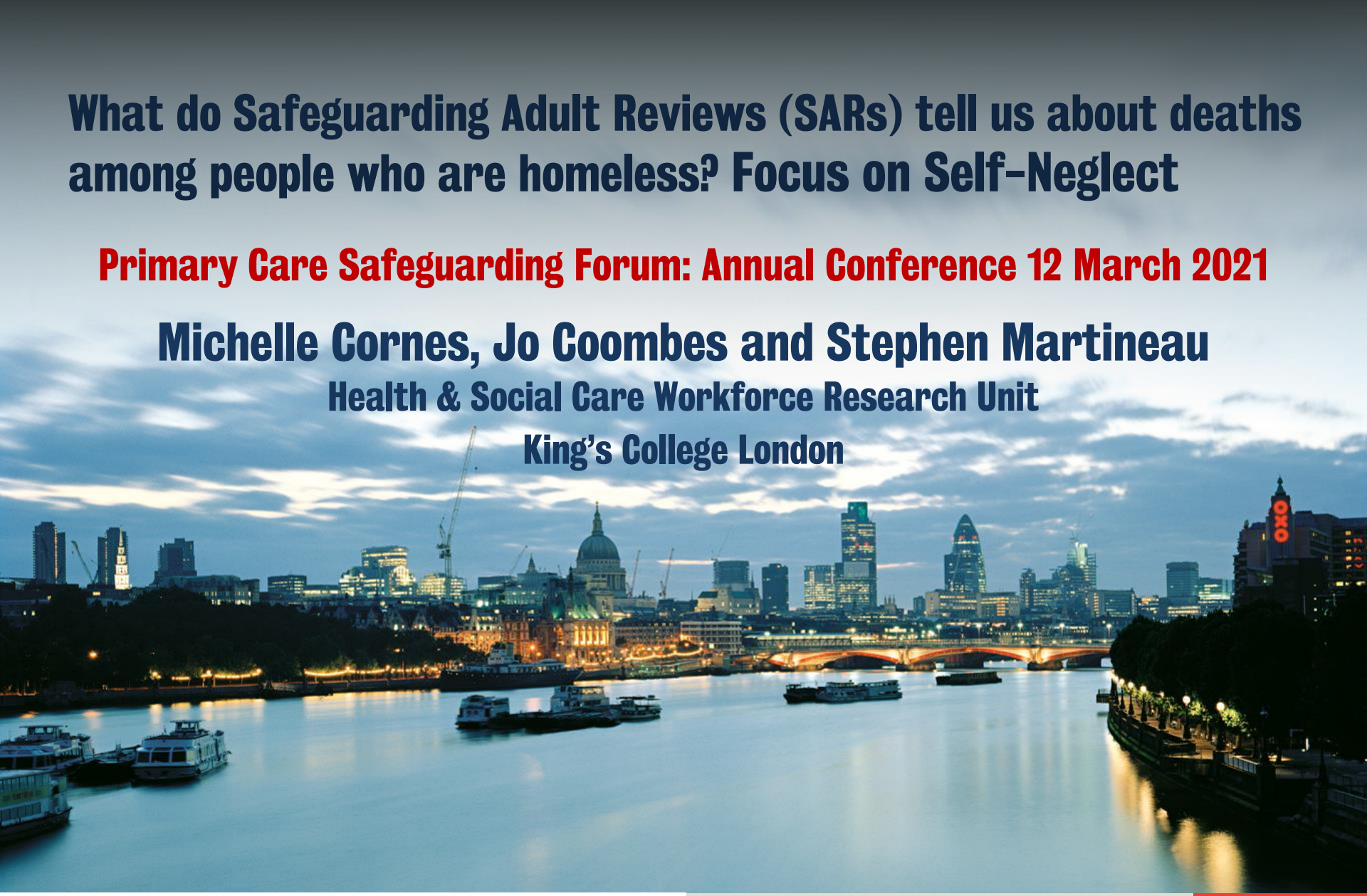

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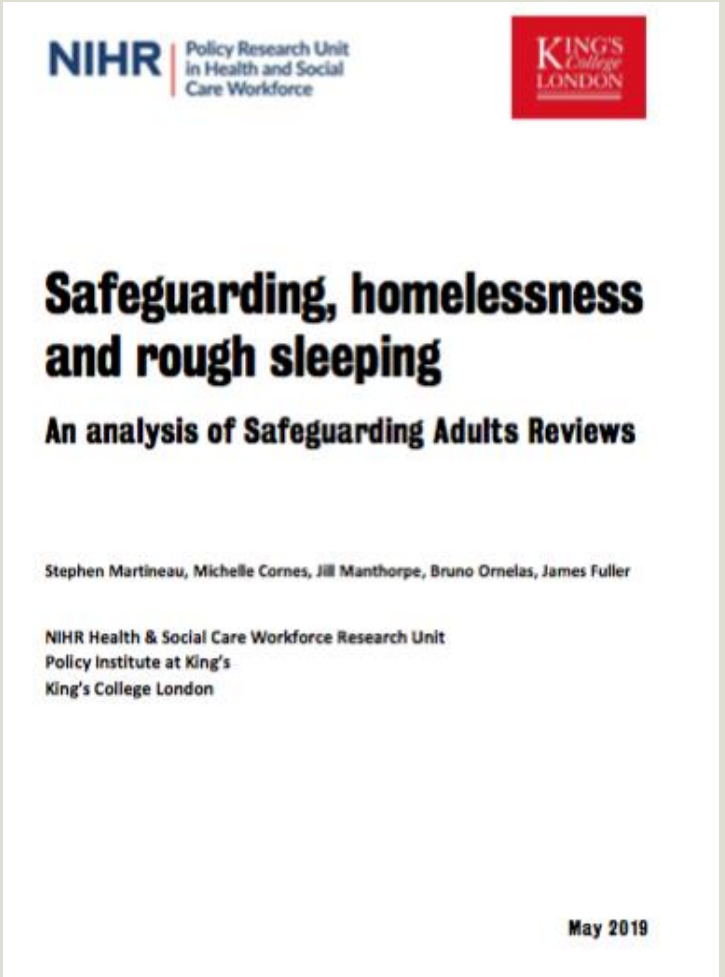
Aim

What do Safeguarding Adult Reviews (SARs) tell us about deaths among people who are homeless?



Multiple Exclusion Homelessness

- Since 2010, the number of people who are homeless in England has increased by 169%.
- Homelessness is not just a housing issue, but it is characterised by tri-morbidity (the overlap between mental health, drug and alcohol, and physical health issues).
- People who are homeless find it difficult to access services especially primary care:
  - Access A&E five to seven times more often that the general population.
  - Average length of stay in hospital three time the national average.
  - Annual costs of unscheduled care for homeless patient is eight times that of the housed population.
  - 70% of homeless patients discharged to the street without having their care and support needs assessed.

Mortality

- There were an estimated 778 deaths of homeless people in England and Wales in 2019 (an increase of 7.2% from 2018).
- Most of the deaths were among men (88.3% of the total).
- The mean age at death was 45.9 years for males and 43.4 years for females.
- Almost two in five deaths of homeless people were related to drug poisoning in 2019.
- Suicides among homeless people increased by 30.2% in one year, from 86 estimated deaths in 2018 to 112 in 2019.

Situation described as a '*public health disaster*' by the British Medical Association

www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations

A Gutter Frame Challenge

0 miles

Tuesday

7.30pm - Discharged from hospital to the street

0.6 miles

Mrs A has no money and it is a 0.6 mile walk to her usual sleep site.

1.7 miles

Wednesday

8.00 - Walk 1.1 mile to the GP surgery – Doors open 9.15

2.3 miles

10.30 - See the nurse – assessed as needing intermediate care but assessor not here.

12.30 - See the GP

3.7 miles

1.30 - Walk 0.6 miles to the day centre to see if they have an emergency bed for tonight. None are available that have disabled access

3.00 - Walk 1.4 miles back to sleep site.

4.8 miles

Thursday

6.4

7am - Walk 1.1 mile to 'appointed' chemist to pick up methadone

9.15 - Walk 1.6 mile back to GPs surgery to be assessed for intermediate care

6.6 miles

12.30 - Walk 0.2 miles to chemist to get dosset box for medications, wait 2.5 hours until chemist has time to help

6.8 miles

3.00 - Walk 0.2 miles back to GP surgery

3.30 - Taxi arrives to take Mrs A to intermediate care bed in a local hostel

Rough Sleeping Strategy 2018

‘We will work with safeguarding adult boards to ensure that safeguarding adult reviews are conducted when a person who sleeps rough dies or is seriously harmed as a result of abuse or neglect and there is a concern that partner agencies could have worked more effectively to protect the adult’

Ministry for Housing Communities and Local Government, 2018

What is a safeguarding adult review?

In 2019, King's College London were commissioned by DHSC 'Rough Sleeping Advisory Group' to review SARs where homelessness was an issue:

'In England, the statutory safeguarding regime is targeted at promoting well-being and addressing the social ills of abuse and neglect. SARs inquire into the aptness of the response of agencies and practitioners with responsibilities in this arena'

(Martineau & Manthorpe, 2020)

'Reviewing SARs builds an evidence base of what good looks like' (LGA/ADASS, 2020 p1)

Type of abuse/neglect

Recorded incidence of actual/suspected abuse and/or neglect across the 19 SARs (21 individual cases) was as follows:

- Physical abuse: 5
- Domestic abuse 1
- Financial abuse: 6
- Modern slavery: 1
- Organisational abuse: 1
- Neglect: 5
- Self-neglect: 14

10/21 Had experience of rough sleeping

18/21 Met the criteria for MEH (tri-morbidity)

5 Themes

- Lack of cooperation coordination and leadership
- Poor Assessment
- Lack of suitable Accommodation
- Hospital discharge
- Ineffective safeguarding:
  - Missed opportunities
  - Making safeguarding personal
  - Lack of professional curiosity
  - Normalising high levels of risk
  - Self-neglect

Focus on Self-neglect

In cases of possible self-neglect, a decision on whether a response will be required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour

- Failure to see and name self-neglect – leading to practitioners not raising a safeguarding concern
- Failure to see chronic alcohol/drug use as self-neglect (a ‘lifestyle choice’)
- Not seeing self-neglect amid a constellation of other issues
- No ‘care needs’: failure to see situation in terms other than housing – service refusal
- Failure to report organisational abuse (e.g. discharge to the street)

What works

- Challenge stigma – see the risks
- Don’t use Mental Capacity Act (‘unwise decisions’’) as an excuse not to help
- Show professional curiosity
- Develop a rapport
- Compassionate kindness
- Just help someone
- And always say hello!

Contact Details & Disclaimer

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Disclaimer: This presentation draws on independent research funded by the National Institute for Health Research (NIHR) School for Social Care Research (SSCR). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health & Social Care.